CENTER FOR FAMILY SERVICES

TAFCAR (Treatment Alternatives for Children at Risk) – Gloucester County

PLEASE FAX or EMAIL

REFERRAL FORM and SPECIAL APPROVAL REQUEST TO:

Program Supervisor: Alyssa Shilinsky

PHONE: 856-728-0404 EXT. 4622 Fax: 856-728-1407

Email: alyssa.shilinsky@centerffs.org

Alternate Contact- Program Director: Sara Gallagher

Phone: 856-964-1990 EXT. 108 Email: sgallagher@centerffs.org

REFERRAL PROCESS

1.) **Please fill out attached referral form to its entirety. Please send supporting documents; i.e. case plan, court orders, and any evaluations for the children and/or parents.**

2.) **Fax the referral to** ***Alyssa Shilinsky at the TAFCAR program at 856-728-1407*****. Upon receiving the referral, an email will be sent to the DCP&P referring worker in reference to the status of the referral, and the assigned TAFCAR worker.**

3.) **The DCP&P case worker, family, and TAFCAR worker must all be present at the intake.**

4.) **During the initial visit, the family's goals and objectives of the intervention will be established, agreed upon, and signed by all parties involved.**

5.) **There should be ongoing contact between all parties regarding the status of the intervention. TAFCAR will send monthly updates to DCP&P regarding the family's progress.**

6.) **TAFCAR Gloucester County will provide services for 12 weeks. When the 12 weeks are coming to a close, all parties will explore the need for case closure or the need to extend services.**

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TAFCAR REFERRAL FORM

Phone: 856-728-0404 EXT. 4622

Fax: 856-728-1407

Instructions: Please fill out all sections of the referral. When faxing the referral, please include DCP&P case plan, court order, any evaluations for the child(ren) and parents, and any other documents that you feel may be helpful to TAFCAR. Also, be sure to attach the SAR. SAR instructions will be outlined below.

Date of Referral: ____________________________ **DCP&P Local Office:** _____________________

DCP&P Referring Worker: ___________________________ **Office #:** _________________________

State Issued Cell Phone: __________________ **Email Address:** _______________________________

DCP&P Supervisor: ________________________ **Office #:** ______________________________

DCP&P Supervisor Email Address: ____

FAMILY INFORMATION

Family/Case Name: _______________________________ **NJ Spirit Number:** _______________

Address: __________________________ **City:** ____________________ **Zip Code:** _____________

Home Telephone: __________________________ **Cell Telephone:** ___________________________

PLEASE LIST OFF ALL HOUSEHOLD MEMBERS

First & Last Name	Sex	Age	Date of Birth	Race	Relationship

Has this family been informed about TAFCAR services? Yes ______ **No** ______

Date of last home visit by DCP&P: ____________

If yes, is the family available for services between the hours of 9am to 6pm? Yes____ No ____ If the family isn't available during these hours, this case may not be appropriate for TAFCAR. TAFCAR Supervisor will conference this case with DCP&P staff.

Brief Family History: ____

____

____

____

____

Goals of TAFCAR services for the family?

1. ____
   ____
2. ____
   ____
3. ____
   ____

Please fill out in regards to the current services the family is involved in.

Family Member	Type of Service	Provider Name	In-home or out of home service?	Frequency of Service

PAYMENT SOURCE

☐ SPECIAL APPROVAL REQUEST (must be signed and faxed with referral)

CFS Tax ID # 22/3669704

TAFCAR RATE: $203.00 per week x 12 (weeks) = $2436.00

Please put the service start date for when you and the family will be available for the intake

DCP&P Referring Worker's Signature: ______________________ Date: ____________

DCPP Supervisor's Signature: ______________________ Date: ____________

Resource Development Specialist Signature: ______________________ Date: ____________